WESTERN SERVICE AREA AUTHORITY (WSAA) STRATEGIC PLAN

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1.0 EXECUTIVE SUMMARY

Please note that this Strategic Plan is a "snapshot" of sorts, an effort to capture in a particular moment in time a picture of mental health services, issues, and needs in (Western) Montana. The WSAA understands that this picture is, by nature, constantly-evolving, as services are added/dropped, as needs change, or as new information comes to light...

The Western Service Area Authority (WSAA), organized in the fall of 2005 as a public benefit/nonprofit corporation, was established by the Montana legislature to collaborate with the Addictive and Mental Disorders Division (AMDD) of the Department of Public Health and Human Services (DPHHS) and Local Advisory Councils (LACs). Through input from consumers, their families, and other interested community stakeholders, the WSAA was created to assist in the planning, implementation, and evaluation of the public mental health care system.

The objectives of the WSAA are to ensure that care provided to individuals with mental disabilities in (Western) Montana is consumer-driven, family-centered, clinically effective and evidence-based, fiscally responsible, recovery-oriented, locally-informed, culturally-competent, holistic, and well-coordinated. The WSAA feels that these objectives will be best achieved by promoting consumer involvement, consumer buy-in, and broad-based participation in the organization and its agenda, by setting (and meeting) achievable short-term and long-term goals, and by establishing the WSAA's credibility in the eyes of legislators, participants in the public mental health care system, and other important stakeholders.

WSAA members and Board members are mental health consumers (primary or secondary) and other stakeholders interested in improving the public mental health system in Western Montana. Voting members must be at least 16 years of age, must reside in one of the 13 counties which constitute the WSAA region, and must have submitted a membership application. They attend quarterly Summit meetings. The WSAA Board of Directors, of which at least 51% must be consumers of mental health services or their family members, is elected by voting members of the WSAA and meets on a monthly basis. The WSAA receives $15,000 per fiscal year from AMDD to support its activities, and it is currently using these monies to support the LACs in the Western region, to pay a "webmaster" to maintain the WSAA website, and to reimburse members for expenses incurred in attending meetings and in discharging duties assigned by the Board.

In terms of "service" provision, the WSAA focuses on the following: (1) consumer empowerment, (2) planning and oversight, (3) education and advocacy, (4) fund-raising, and (5) coordination of activities with the Eastern and Central SAAs. The WSAA does not provide direct mental health services. Along with the ESAA and CSAA, the WSAA works with the Mental Health Oversight Advisory Council, the Mental Health Ombudsman, the National Alliance for the Mentally Ill, the Montana Mental Health Association, the Montana Advocacy Program, the Mental Disabilities Board of Visitors of the State of Montana, and other entities that conduct legislative activities, provide oversight and input into the public mental health system, and offer education and advocacy regarding mental health issues in (Western) Montana.

The WSAA recognizes that there is a vast need for public mental health care in Western Montana and in the rest of the state. Although many services and programs currently exist in the Western region (and especially in Missoula County), the WSAA has identified as particularly critical the need for the following: presumptive eligibility, emergency assistance, emergency room professional assistance and training, automatic enrollment in the mental health system, discharge medications, increase in the Mental Health Services Plan (MHSP) poverty level, training for law enforcement personnel, peer support services, enhanced services for 90 days for individuals discharged from the state hospital, higher reimbursement rates for providers, humane transportation of consumers to involuntary services, upgraded crisis bed availability, enhanced PACT services, special needs wrap-around funding for patients discharged from the state hospital, patient assistance in community settings, a state-wide Crisis Help Line, better access to pre-adjudication evaluations, hospital crisis aide reimbursement, higher daily reimbursement to community hospitals, regional assessment and evaluation centers, and transitional services and supports for individuals with mental illness who are released from prison or jail.

The WSAA has also identified numerous obstacles that may interfere with its effectiveness in helping the public mental health system address critical service needs. These include: a lack of political focus/will to improve the mental health system, a lack of organization among people working in and using the public mental health system, compassion fatigue and burnout, difficulty hiring and retaining competent professional staff, difficulty obtaining local intensive mental health supports and resources, criminalization of the mentally ill, a lack of consumer involvement in quality control of community services, the lack of realistic financing for public mental health services in the community, over-reliance on Medicaid funding, the shrinking federal Medicaid budget, competing priorities, stigma and lack of education regarding mental illness, the strength/influence of AMDD, and potential threats to the survival of the SAAs.

In order to overcome some of these obstacles and to maximize its effectiveness, the WSAA plans to adopt the following strategies: (1) conduct a thorough market analysis to get a clearer picture of the status of mental health services in Western Montana, (2) conduct a thorough needs assessment to identify deficiencies, community needs, and service priorities, (3) present a unified voice by collaborating, coordinating efforts, and combining resources with the Central and Eastern SAAs and other community mental health groups, when appropriate, (4) collaborate with AMDD/DPHHS to develop budget priorities, service priorities, and methods to meet those needs, (5) participate in the legislative process, (6) engage in grant-writing and other fund-raising, (7) promote "best practices," (8) promote consumer involvement, (9) promote insurance parity, (10) participate in AMDD's Request for Proposals (RFP) process by encouraging and supporting consumers and other stakeholders to develop responses to deficiencies in the public mental health system, and (11) rate the mental health system.

1.1 Mission

The Western Service Area Authority (WSAA) was established by Montana State statute to collaborate with the Department of Public Health and Human Services (DPHHS) and Local Advisory Councils (LACs) in the planning, implementation, and evaluation of a consumer-driven, recovery-oriented, culturally-competent public mental health care system. Our mission is to ensure that consumers, their families, and other interested community stakeholders have a

strong voice in defining, developing, managing, and monitoring public mental health care delivery in Montana, with a focus on the Western region of the state.

1.2 Objectives

The objectives of the WSAA are to ensure that care provided to individuals with mental disabilities in (Western) Montana is (in no particular order):

(a) **Consumer-driven, so that consumers' needs and preferences significantly** influence the services provided, and so that consumers have some choice regarding their services and providers;

(b) **Family-centered**, thereby ensuring that consumers and their families assume greater leadership in the public mental health care system (e.g., have a stronger voice in managing funding for services, treatments, and supports);

(c) **Clinically effective and evidence-based**, in order to enhance accountability, ensure a continuum of care, and promote "best practices";

(d) **Fiscally responsible**, to ensure the most efficient use of resources possible, given the budget constraints for each service region and the state as a whole;

(e) **Recovery-oriented**, i.e., focused on meeting basic needs, enhancing coping skills, facilitating recovery, promoting independence, and building resilience;

(f) **Locally-informed**, i.e., reflective of and responsive to the needs, exigencies, and solutions identified by significant stakeholders from the communities in which it is delivered;

(g) **Culturally-competent**, i.e., sensitive to, respectful of, and competent regarding important dimensions of human experience (e.g., race and ethnicity, gender, sexual orientation, religious affiliation) as they may relate to a consumer's treatment and recovery;

(h) **Holistic**, i.e., addressing all aspects – physical, psychological, emotional, social, and spiritual – of a consumer's treatment and recovery; and

(i) **Well-coordinated**, when necessary or appropriate, with that provided in the Central and Eastern regions of the state.

1.3 Keys to Success

(a) **Consumer involvement:** Requiring a minimum of 51% consumer involvement will help to ensure that the needs and wishes of consumers are truly represented.

(b) **Consumer buy-in:** Putting the needs of consumers first, giving them 51% control, and getting them involved in the leadership of the WSAA will all help consumers to feel that their participation is valued and actually makes a difference.

(c) **Broad-based participation:** Bringing a number of stakeholders (consumers, family members, providers, mental health professionals, administrators, and staff) to the table will help to ensure that multiple viewpoints are represented, that checks and balances are built into the system, and that the organization will be more stable.

(d) **Achievable goals:** Setting (and meeting) achievable short-term and long-term goals will help to give the WSAA a sense of purpose and efficacy and make it easier to measure its impact.

(e) **Credibility:** Putting consumers first, fostering broad-based participation, and achieving its goals will all help the WSAA to be more responsive to the needs of the individuals it represents and help it to establish credibility in the eyes of legislators, participants in the mental health care system, and other important stakeholders.

2.0 ORGANIZATIONAL SUMMARY

The WSAA was organized in the fall of 2005 as a public benefit/nonprofit corporation under Montana statute. The statute defining Service Area Authorities (SAAs) is MCA §53-21-1001. The purpose of the corporation is to collaborate with the Department of Public Health and Human Services (DPHHS) and to assist in the planning, implementation, and evaluation of public mental health care. The geographic area assigned to the WSAA by DPHHS includes the following 13 counties: Beaverhead, Deer Lodge, Flathead, Granite, Lake, Lincoln, Madison, Mineral, Missoula, Powell, Ravalli, Sanders, and Silver Bow. (According to 2005 Census estimates, these counties combined comprised 37.8% of the state's population.) The WSAA is one of three (i.e., Western, Eastern, and Central) regional SAAs in Montana which individually focus on a separate region of the state and jointly focus on a limited number of issues of concern to the entire state public mental health system.

2.1 Legal Entity

The Western Service Area Authority, Inc. is a public benefit corporation which is incorporated as an instrumentality of the State of Montana.

2.2 Organizational History

In 1999, the Montana legislature recognized the need for local participation in planning for mental health services, prompting the formation of Local Advisory Councils (LACs). The LACs were the grassroots foundation for the SAAs. In October 2004, the initial WSAA planning meeting was held in Missoula, MT, in response to the establishment of the SAAs by the Montana legislature. A WSAA leadership planning committee was established in May 2005, and temporary officers were elected. In August 2005, the WSAA's Articles of Incorporation were filed with the Montana Secretary of State, and the organizational by-laws were adopted by the

WSAA planning committee and WSAA general membership in October 2005. At the same time, the WSAA Board of Directors was also elected.

2.3 Governance Structure

WSAA Membership
WSAA members can be mental health consumers (primary or secondary) or other stakeholders interested in improving the public mental health system in Western Montana. Voting members of the WSAA membership must be at least 16 years of age, must reside in one of the 13 counties which constitute the WSAA region, and must have submitted a membership application attesting to both their age and county of residence.

WSAA Board of Directors
The WSAA Board of Directors (limited to 15-19 Directors) is elected by voting members of the WSAA. The majority (at least 51%) of the WSAA Directors shall be consumers of mental health services or family members of consumers (i.e., primary or secondary consumers). All Directors serve 3-year terms of office. The Directors annually elect a slate of 4 Officers (the Executive Board): President, Vice President, Secretary and Treasurer.

Currently, up to ten (10) of the nineteen (19) directorships are reserved for election directly by up to ten (10) Local Advisory Councils (LACs). (Each LAC may appoint one non-voting alternate to the Board who shall have voting rights when the primary LAC Director is absent.) The WSAA requires that any LAC member voting for an LAC representative Director to the WSAA Board also complete and submit membership forms to the WSAA, thus ensuring that the WSAA Board is elected by its members. The WSAA has also requested that all LAC representative Directors be either primary or secondary consumers of public mental health services. In addition, up to nine (9) Directors shall be elected from other interested stakeholder groups (e.g., state mental health system, law enforcement, criminal justice system, county commissioners, Western Montana Mental Health Center, private clinicians, crisis response teams, vocational rehabilitation, housing agencies, substance abuse treatment providers, Native American communities, etc.). The Board of Directors is responsible for voting to fill vacancies for non-LAC seats.

Meetings
The full WSAA membership holds an Annual meeting on the 3rd Wednesday of September. The WSAA Membership or Board of Directors may host 3 additional quarterly (Congress) meetings. The Board of Directors meets monthly (3rd Wednesday of the month) at St. Patrick Hospital, Missoula.

3.0 SERVICES

The WSAA is involved in the following activities and events:

1. Holds monthly Board of Directors meetings;
2. Holds 3 quarterly Congress meetings (and one quarterly Annual meeting);

3. Participates in regularly-scheduled Service Area Authority (SAA) Summit meetings throughout the year;
4. Collaborates actively with the State of Montana AMDD; and
5. Educates legislators and other key stakeholders about pressing mental health issues in Western Montana.

3.1 Service Description

The WSAA provides the following services:

(a) **Consumer empowerment:** (1) Provides forum for consumers of mental health services and all other concerned stakeholders to be heard with regard to mental health issues in Western Montana; and (2) fosters and supports the growth and recovery of individuals with mental illness through placement in leadership roles throughout the WSAA.

(b) **Planning and oversight:** (1) Collaborates with the State of Montana AMDD for purposes of planning and oversight of mental health services in the Western service area, including: (a) provider contracting, (b) quality and outcome management, (c) service planning, (d) utilization management and review, (e) preadmission screening and discharge planning, (f) consumer advocacy and family education and rights protection, (g) infrastructure, (h) information requirements, and (i) procurement requirements; (2) reviews and monitors crisis intervention programs established pursuant to MCA §53-21-139; and (3) submits a biennial review and evaluation of mental health service needs and services within the Western service area.

(c) **Education and advocacy:** (1) Provides data and information to AMDD, LACs, and other stakeholders regarding mental health issues in the Western region and statewide; (2) educates legislators regarding mental health issues pertinent to Western Montana; (3) educates the community through dissemination of factual information in order to reduce stigma surrounding mental illness; and (4) participates in advocacy of policy positions that the SAAs develop and support.

(d) **Fund-raising:** Initiates fund-raising activities and seeks out additional revenue through various activities for the purpose of improving mental health services in Western Montana.

(e) **Coordination:** (1) Coordinates with Eastern and Central SAAs in the development of a state-wide mental health agenda; (2) coordinates with the Eastern and Central SAAs in the development of a statewide communication system regarding mental health issues; and (3) considers the policies, plans, and budget developed by the children's system of care planning committee provided for in MCA §52-2-303.

Note: the WSAA does not directly provide mental health services.

3.2 Complementary Resources/Related Entities

While there are no direct 'competitors' to the WSAA, the following entities also conduct legislative activities, provide oversight and input into the public mental health system, and offer education and advocacy regarding mental health issues in Western Montana. The WSAA will need to be clear about its distinct mission in order to provide effective services and to avoid duplication of efforts.

(a) **Mental Health Oversight Advisory Council (MHOAC)**, established in 1999 by MCA §53-21-702, to provide input to the department in the development and management of any public mental health system;

(b) **Mental Health Ombudsman,** defined in MCA §2-15-210, who represents the interests of individuals with regard to the need for public mental health services, including individuals in transition from public to private services;

(c) **National Alliance on Mental Illness (NAMI),** the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. NAMI provides advocacy, research, support, and education;

(d) **Montana Mental Health Association (MMHA)**, a nonprofit association of volunteer citizens concerned with all aspects of mental health and mental illness. MMHA educates by sponsoring professional conferences and advocacy workshops for consumers, families, professionals and the general public;

(e) **Montana Advocacy Program, Inc. (MAP)**, a federally-funded nonprofit corporation which advocates for the rights of people with mental illness under the authority of the federal Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act). Montana incorporated the PAIMI Act into state law at MCA §53-21-169; and

(f) **Mental Disabilities Board of Visitors of the State of Montana**, which reviews Montana's public mental health programs and the Montana Developmental Center and assists individuals receiving services from those programs. The Board of Visitors was established in 1975 by MCA §53-21-104 and §2-15-211.

3.3 Printed Materials

(a) **WSAA Strategic Plan:** The goal of this strategic plan is to provide an educational document which outlines the WSAA's mission, objectives, and history, and which provides a "blueprint" for its future activities, in order to enhance its effectiveness.

(b) **WSAA Records:** The WSAA keeps all records (e.g., Minutes and Treasurer's Reports) from each Board of Directors and Congress meeting. These records are available to all members and to DPHHS via e-mail or the WSAA website (see section 3.5. "Technology").

(c) **SAA Brochure:** The SAAs will explore the possibility of developing a printed brochure outlining the three SAA regions and their primary objectives and functions. This would facilitate education regarding the SAAs and their mission.

(d) **Mental Health Local Advisory Council Handbook (Revised – January 2006):** Handbook developed by MHOAC (revised and condensed by Daniel Ladd, Regional Planner, Mental Health Bureau, AMDD) to help new LACs to get off the ground.

3.4. Fulfillment

(a) The three SAA Executive Committees will meet at regularly-scheduled Summit meetings throughout the year to discuss, comment upon, and take concerted action on statewide issues, where appropriate;

(b) The three SAA Executive Committees, in consultation with AMDD, will develop mechanisms for effective communication and collaboration;

(c) The WSAA will establish sub-committees, when appropriate, to tackle issues and problems of importance to the fulfillment of its mission; and

(d) The WSAA will educate and disseminate critical information to legislators and other important stakeholders as deemed necessary.

3.5. Technology

To assist in the dissemination of critical information, the WSAA will develop and maintain the following:

(a) **Website:** for the purpose of keeping members informed about the WSAA through the posting of meeting minutes, descriptions of various activities, and information about key mental health issues in Western Montana. (The WSAA hired its own "webmaster," and he developed the website: www.WSAAMT.org.)

(b) **E-mail List:** with current e-mail addresses for all members; and

(c) **(Potential) Newsletter:** for dissemination to WSAA members who do not have easy computer access.

3.6 Future Services

Future services will be those deemed appropriate by the Congress and approved by the Board of Directors.

4.0 MARKET ANALYSIS SUMMARY

Although not broken down by service area, the following statistics provided by AMDD help us to appreciate the magnitude of the problems facing the public mental health system in Montana:

- **Mental Illness:** it is estimated that 1 in 5 Americans suffers from some kind of mental disorder in a given year. In 2003, AMDD provided mental health services to about 1 in 30 Montanans, children and adults.

- **Suicide:** Montana ranks second in the nation in the incidence of suicide.

- **Montana State Hospital:** 782 Montanans were hospitalized at MSH in FY 2004 (189 average daily census).

- **Substance Abuse:** 1 in every 12 Montanans aged 12+ was in need of treatment for a substance abuse disorder in 2001. It is estimated that 50-60% of Montanans who have a mental illness also have a substance abuse disorder.

- **Medicaid:** 13,082 unduplicated Montanans received Medicaid-supported mental health services in FY2004.

- **Mental Health Services Plan:** 4,977 Montanans received MHSP-supported mental health services in FY2004 (2,187 monthly average).

In addition, AMDD provided the following statistics, by county, for individuals diagnosed with depression, bipolar disorder, and schizophrenia who were provided public mental health services in the Western Service Area in 2005:

- **Depression:**

County	Frequency	Percent	Cumulative Frequency	Cumulative Percent
MISSOULA	881	26.01	881	26.01
FLATHEAD	609	17.98	1490	43.99
SILVER BOW	462	13.64	1952	57.63
RAVALLI	347	10.25	2299	67.88
LAKE	301	8.89	2600	76.76
LINCOLN	227	6.70	2827	83.47
DEER LODGE	161	4.75	2988	88.22
SANDERS	117	3.45	3105	91.67
BEAVERHEAD	114	3.37	3219	95.04
MINERAL	78	2.30	3297	97.34
POWELL	48	1.42	3345	98.76
MADISON	25	0.74	3370	99.50
GRANITE	17	0.50	3387	100.00

- **Bipolar Disorder:**

County	Frequency	Percent	Cumulative Frequency	Cumulative Percent
SILVER BOW	330	27.34	330	27.34
MISSOULA	271	22.45	601	49.79
FLATHEAD	169	14.00	770	63.79
DEER LODGE	106	8.78	876	72.58
RAVALLI	74	6.13	950	78.71
LAKE	70	5.80	1020	84.51
LINCOLN	64	5.30	1084	89.81
BEAVERHEAD	40	3.31	1124	93.12
POWELL	25	2.07	1149	95.19
SANDERS	22	1.82	1171	97.02
MINERAL	21	1.74	1192	98.76

GRANITE	8	0.66	1200	99.42
MADISON	7	0.58	1207	100.00

- **Schizophrenia:**

County	Frequency	Percent	Cumulative Frequency	Cumulative Percent
MISSOULA	179	34.10	179	34.10
FLATHEAD	100	19.05	279	53.14
SILVER BOW	69	13.14	348	66.29
DEER LODGE	53	10.10	401	76.38
LAKE	33	6.29	434	82.67
RAVALLI	30	5.71	464	88.38
LINCOLN	22	4.19	486	92.57
BEAVERHEAD	13	2.48	499	95.05
POWELL	10	1.90	509	96.95
SANDERS	8	1.52	517	98.48
GRANITE	4	0.76	521	99.24
MINERAL	4	0.76	525	100.00

It should be noted and emphasized that these figures do not include all individuals in Montana State Hospital (Warm Springs) or Montana State Prison (Deer Lodge), two state-wide facilities located within the Western region that serve a disproportionately high number of individuals with mental illness. (A September 2006 Justice Department's Bureau of Justice Statistics (BJS) study found that 43% of state prisoners had symptoms of mania, 23% had symptoms of major depression, and 15% had symptoms of psychotic disorder. These numbers were even higher for female inmates: in state prisons, 73% of females (and 55% of males) had mental health problems. Inmates with a mental health problem also had high rates of substance dependence or abuse in the year before their admission.) **In addition, these statistics do not include individuals with private health insurance, individuals with these mental illnesses who did not come to the attention of the public mental health system, or individuals with other significant mental health diagnoses. Thus, these figures significantly under-represent the number of individuals living within the Western service area who are living with mental illness and who need mental health services.**

4.1 Services Currently Available

(a) Statewide Services:

- **Montana State Hospital:** MSH is the only inpatient stabilization service available to many people living with mental illness in Montana who are uninsured. Although MHS is located in the Western service area, individuals with mental illness are admitted to the hospital from all over the state. (See Appendices A-D for statistics on MSH admissions, discharges, average daily census, and average # of admissions by month, from 1995 – 2006).

  A "snapshot" of 194 MSH patients taken on 11/6/05 revealed that 46% (N = 90) came from the Western service area, including 11 from Flathead, 27 from Missoula, and 30 from Silver Bow counties. These numbers indicate that the Western region as a whole was over-represented in the hospital population, given that the 13 counties that constitute the Western region represent only 37% of the total population of Montana. These numbers also suggest that particular counties (e.g., Missoula, Powell, and Silver Bow) may be over-represented in the hospital population. It may be beneficial to examine

these counties more closely, to try to determine whether their demographics, lack of other inpatient options in these counties, or other factors account for these numbers.

State officials report that more than half of the people admitted to MSH have neither private insurance nor Medicaid. The cost of managing mental health crises by sending people to MSH is therefore enormous. MSH is budgeted at $26,800,000 for FY 2006 ($27,900,000 for FY 2007). The budget includes all costs associated with operating the hospital, including a bond payment of approximately $1.7 million each year. The bonds were issued back in 1997 to pay for the construction of the "new" hospital. The State Hospital census has increased from an average of 182 patients per day in 1997 to 195 per day in 2006. Meanwhile, admissions to the Hospital almost doubled, from 327 admissions per year to 721. In response, DPHHS has hired 36 new staff and is asking the Legislature for an additional $1.7 million per year to pay for them. That's $1.7 million that could be used to pay for crisis management in the communities where people live.

- **Crisis Hotlines:** the State of Montana provides funding for a 24-hour/7-day a week telephone crisis hotline available to citizens throughout the state. The hotline also provides information and referral.

  All licensed mental health centers and licensed private practitioners are required to provide a 24 hour/day emergency response to their current active clients. Most ethical providers do, in fact, take this responsibility seriously and make arrangements for after (business) hours coverage. The expectation should be that therapists are available to their clients in a crisis situation because that is where the therapeutic alliance has been established and the individual's therapist is, or should be, the best source for helping the clients resolve an emergency situation.

  WMMHC and AWARE both have a 1-800 telephone hotlines for their respective clients in MT, including WSAA counties. If someone calls in crisis, the hotline (which is staffed and has an on-call therapist) will determine what the issues are, try to assess the seriousness of the emergency call, offer support and assistance, and if the situation warrants immediate attention, will refer the caller to the nearest health care facility (which is generally a hospital emergency room). Depending on the situation, the ER may arrange a face-to-face assessment which can result in an emergency detention and a petition for involuntary commitment.

- **Inpatient Mental Health Treatment:** other than MSH, there are two inpatient psychiatric hospitals in the WSAA region – one in Kalispell (Pathways Treatment Center: an 18-bed psychiatric adult unit, a 16-bed adolescent unit, and 3-bed "special care unit," and a chemical dependency treatment unit) and the other in Missoula (St. Patrick Hospital: 28 beds, 7-14 of which are available to patients from the publicly-funded mental health system). However, these two hospitals serve patients from all over Montana, not just the Western region.

(b) Other Adult Mental Health Services:

- **Program of Assertive Community Treatment (PACT) Information:** there are two PACT programs in the WSAA region: one in Kalispell and the other in Missoula. On December 1, 2005, the Kalispell program had 56 patients and the Missoula program had 48 patients. Each of these programs has the capacity to expand to up to 60 clients.

- **Mental Health Professional (MHP) Services Data:** in FY 2005, mobile crisis teams in the WSAA region received a total of 6,675 calls and provided 2,445 face-to-face contacts. Of these contacts, 34.5% took place in the Kalispell area, 28.8% in the Missoula area, and 36.7% in the Butte/Anaconda/Dillon area.

- **Adult Case Management:** this service component is the primary community-based support available to individuals with serious and disabling mental illness. The program enjoys widespread participation by consumers in all 12 counties covered by the WSAA. The program provides a wide array of supports, including: linkage with other health care and mental health services, housing support, income support and assistance in negotiating community services so that individuals can develop a recovery focus in their lives.

- **Medical Services:** a major component in the treatment of major mental illnesses is access to psychiatrists and their medical expertise in prescribing medications and monitoring the patient's progress with symptom management. Recently, WMMHC and several other providers have been able to utilize Advanced Practice Registered Nurses (APRN) for this critical function as well. Recovery only becomes an option for individuals if they are symptom-free or least symptom-minimized. There is nationally a shortage of community psychiatrists, and Western Montana (particularly the rural communities) experiences that critical shortage.

- **Outpatient Services:** this service is perhaps the most available option for persons experiencing mental health difficulties. Western Montana has a large number of licensed therapists (Psychiatrists, Psychologists, Licensed Clinical Social Workers, and Licensed Professional Counselors). Licensed master's level clinicians are available in virtually every community in the area, whereas psychiatrists and psychologists tend to be available only in major urban centers. This service is almost always office-based and consists of individual or group therapy offered on some regularly scheduled basis (e.g., twice a month for 1 hour per session). Many private therapists have elected to limit or not take state Medicaid clients due to regulatory and funding restrictions, and they have a limited ability to see clients who cannot afford to pay the full cost of care by themselves. Most insurance policies have higher deductibles and/or co-pays for mental health services than regular health services, and other limiting features which often make insurance for mental health services less available than for other medical/health issues.

- **Crisis Facility Data:** there were 524 referrals in FY 2005 to the three crisis facilities located in the WSAA region: Kalispell Safe House, Stephens House (Missoula), and Gilder House (Butte). Of these referrals, 502 clients (96%) were admitted to the facilities, and they stayed for a total of 4,501 client days. Stephens House accounted for 42.7% of the admissions and 44% of client days, followed by Kalispell Safe House

(28.5% of clients, 22% of client days) and Gilder House (26.9% of clients, 33.8% of client days).

- **Other services:** although AMDD keeps statistics on other adult mental health services provided in the state, it does not break those numbers down by region.

(c) **Children's Mental Health Services:**

- **Children's Mental Health Bureau:** in Montana, mental health services for children with serious emotional disturbance (SED) are primarily provided through the Children's Mental Health Bureau under DPHHS. These include Medicaid-supported services such as inpatient psychiatric services, community-based services, community-based outpatient services, and services provided by mental health professionals. The bureau also manages non-Medicaid programs for children with SED under the Children's Mental Health Service Plan, which is limited to low-income youth who are within 150% of the federal poverty guidelines and who are not eligible for Medicaid or the Children's Health Insurance Plan (CHIP). State funding for non-Medicaid and non-CHIP youth is negligible. The State of Montana has relied primarily on Medicaid funded services plus the recent addition of CHIP for non-Medicaid eligible youth. The services covered under CHIP are limited primarily to traditional outpatient coverage. A significant portion of children's mental health services and supports are provided through the schools under the CSCT program, a joint initiative (for Medicaid eligible youth) between local school districts and a local mental health center. The CSCT initiative is the primary vehicle for supporting youth who require extensive support in the classroom and well as assistance with peer and family interactions. CSCT is available primarily to Medicaid eligible youth because that is the only funding source for these programs. In addition, a number of providers offer children's group homes and supported living services to families to help keep children in their own homes. Finally, children with SED may be victims of abuse or neglect and may be served by the Child and Family Services Division and Child Protective Services. An unknown number of children with SED also end up in local juvenile detention facilities and the State facilities for boys and girls.

  The Children's Mental Health Bureau has made a concerted effort to identify, monitor and bring back Montana's high needs children receiving services in other states and to foster development of in-state resources. However, it is challenged by rigid licensing and funding rules, depressed Medicaid payment schedules, and limited professional resources. Consequently, approximately 80%+ of all funding for children's mental health services goes to support out-of-home care for youth in group homes, in-state residential care facilities, or out-of-state residential placements.

  Approximately 25% of Montana's children live in poverty. Another significant percentage lives in the gray area slightly above the federal poverty level. Theoretically, any child eligible for Medicaid should receive all services which are medically necessary to screen, diagnose and treat a child with SED under the Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions of Medicaid. However, Montana has been slow to implement EPSDT, lacks qualified child psychiatrists and other mental health

professionals in many areas of the state, and has few or no guidelines for screening children for SED. Moreover, children who are eligible for CHIPS or the Children's Mental Health Plan receive significantly fewer mental health services than children who are Medicaid eligible. Montana has also failed to adequately increase funding for special education in schools, which bear much of the responsibility to provide supports and services necessary to allow a child with SED to progress in the curriculum.

- **Kids Management Authorities (KMAs)** have some similarities to the LACs/SAAs, in that the legislature established them to support a comprehensive and statewide system of mental health care for children, by developing a continuum of care in local communities and providing case planning and coordination for individual youth with SED and their families. Major differences between the two structures are that KMAs are organized by county, have no regional governance structure, and are primarily focused on coordinating individual treatment plans between the various treatment entities, school personnel, custody agencies, and where feasible, the parent of the child being "staffed". There is a very limited role for parents/consumers in the KMA structure other than as parent advocates for their individual case involvement. The SAAs have been mandated by the legislature to work with the KMAs and the children's mental health system.

  Theoretically, there are many more services available in the children's system because EPSDT mandates that all Medicaid-eligible children receive all medically necessary services. However, because Montana has not developed financing incentives to support a broad array of community supports for youth, the only options available to parents are often placement in a group home, limited case management, or limited outpatient services. The fragmentation of multiple service providers, coupled with no clear locus of responsibility at the community level, has impaired the development of a comprehensive children's mental health system. In contrast, mental health is an optional program under Medicaid for adults and can be limited in any number of ways if the limitation applies to all eligible adults. Unfortunately, although the teenage years are often when serious mental illness first appears, the state-defined diagnoses for SED youth often do not translate into eligibility for adult programs with more restricted adult diagnostic definitions for SDMI. Thus, collaboration between the SAAs and KMAs will be critical to smooth and strengthen the precarious transition between the children's mental health system and the adult system.

(d) Breakdown of Available Adult Services, by County, in the Western Service Area:

Please note that this is <u>not</u> an exhaustive list of available services, but rather a listing of those services of which the committee was aware at "press-time"...

- **Missoula County**

  Crisis Response: Missoula County partially funds a 24/7 mobile Crisis Response Team (CRT), supervised by the Western Montana Mental Health Center (WMMHC), to provide full crisis services. These include in-person evaluations and assistance by one of four mental health professionals (MHPs) at emergency rooms, upon police or sheriff

request, at the crisis houses, or at a person's home or other community site. St Patrick Hospital is currently in negotiations with WMMHC to provide additional assistance to ER physicians regarding dispositional alternatives for non-dangerous patients at the emergency room. St. Patrick Hospital further supports crisis services through WMMHC for next-day follow-up appointments and a one hour psychiatrist's visit for individuals referred from the emergency room. In addition, St. Patrick Hospital supports next-day follow-up care at the Turning Point chemical dependency treatment center operated by WMMHC for patients referred from its emergency room. St. Patrick hospital has a contract with Turning Point/SHARE House to provide non-medical detoxification services to emergency room patients who have been medically cleared by ER physicians for referral to SHARE house.

Crisis Residence: Missoula is home to Dakota House (formerly "Stephens House"), a 7-bed crisis house which is primarily reserved for residents of Missoula County. The new Stephens House has recently opened with 3 crisis beds and 2 transitional beds (from inpatient facilities). Stephens House will reserve one bed for step-down services for patients being discharged from MSH under a recently-signed contract with Montana State Hospital. The crisis residential program served 153 unduplicated individuals in FY 06.

Outpatient Services: Missoula is home to the WMMHC outpatient mental health treatment center which provides adult case management, psychiatric evaluation, medication management and supports, day treatment services, PACT, emergency services, and referral to crisis and group homes or supported-living services for those in their own home in Missoula. The adult mental health programs in Missoula County served 1,588 unduplicated individuals in FY 06. AWARE also provides adult case management, although they are drastically downsizing in Missoula and down to 2 adult case managers.

Inpatient Services: St. Patrick Hospital Providence Center has a psychiatric ward with 28 total beds. However, the emergency beds are very limited: although seven (7) adult and seven (7) adolescent beds may be available for patients in the public mental health care system, only a few are intensive-care beds on a secure unit. In addition, St. Patrick Hospital provides 14 in-patient beds to private community psychiatrists with admitting privileges. A limited number of beds are available for Medicaid reimbursement, and remaining beds have specific use designations such as chemical dependency or adolescent versus adult. Consequently, at any given time, it is nearly impossible to predict whether Providence Center will be able to accept patients in a mental health crisis. The major problem with the availability of public beds has been the shortage of psychiatrists to provide inpatient attending duties.

Mental health providers in the community have raised concern that when their patients are hospitalized at the Providence Center, they do not feel that the hospital staff has the time or resources to collaborate with them effectively. Consequently, many patients are discharged from the hospital without any consultation with their treating providers, and the providers are sometimes not even informed about the discharge until after it has taken place.

Children's Mental Health Services: in Missoula County, AWARE has 4 therapeutic group homes for children. Youth Homes, Inc. provides a network of 8 therapeutic group homes for boys and girls, numerous therapeutic foster care homes, and a shelter care facility. WMMHC offers youth case management services, outpatient services, medical services, and comprehensive school and community treatment (CSCT) to 10 separate school sites in Missoula County. In FY 06, WMMHC child mental health programs served 783 unduplicated clients. Friends to Youth provides an array of community based services, including outpatient and family based treatment intervention in the youth's home. The University of Montana Clinical Psychology Center also provides a limited amount of child treatment on a sliding scale to uninsured children and their families. Finally, Missoula County is also home to more than 250 private therapists who are providers of outpatient services to youth and their families.

Children's Substance Abuse Services: The Flagship program (a substance abuse prevention effort) operates in 12 Missoula Public school settings. Project Success has licensed addiction counselors stationed at the 4 Missoula Public High Schools. The Teen Recovery Center, operated by Turning Point, provides inpatient/residential care to 8-10 youth.

Chemical Dependency Treatment: Turning Point, sometimes referred to as Western Montana Addiction Services (WMAS), provided outpatient chemical dependency treatment services to 1,789 individuals in FY 06. In addition, Turning Point operates SHARE House (a chemical dependency/co-occurring treatment group home with 14 beds and two community social detoxification beds) and Graham Home, a residential recovery program for women and children (capacity of six family units). SHARE House is dually-licensed by DPHHS to handle both CD and mental health issues. St. Patrick Hospital provides screening services for detoxification and then referral to available beds at Share House, as appropriate. Turning Point is an affiliate of WMMHC and is co-located on the Wyoming Street campus adjacent to the child and adult mental health programs offered by WMMHC at that same location. Finally, St. Patrick Providence Center allocates a few beds, generally 1-4, for chemical dependency inpatient treatment.

Vocational Services: WMMHC has designated one staff person to provide employment related services. She may set up work assessments sites in the community, provide job search assistance or job coaching, or coordinate supported employment services (extended follow along support). In many ways she serves as a liaison between WMMHC-Missoula and Vocational Rehabilitation.

- **Superior/Mineral County and Thompson Falls/Sanders County**

Crisis Response: Mineral and Sanders Counties do not have 24-hour emergency on-call availability. However, therapists may be reached after-hours to assist with emergency situations.

Outpatient Services: Superior and Thompson Falls are home to two separate WMMHC outpatient mental health centers, which provide a full range of case management, limited psychiatric services, and individual treatment through a staffed facility. Both mental health centers have programs available within their respective schools. In FY 06, Mineral County WMMHC programs served 203 unduplicated individuals and Sanders County programs served 326 individuals.

Chemical Dependency Treatment: Western Montana Addiction Services has a satellite office in Mineral County.

- **Kalispell/Flathead County**

Crisis Response: Kalispell/Flathead County and a consortium of medical and other community providers partially fund a CRT to provide a full-service crisis response team operated by the WMMHC, for MHPs to do in-person evaluations at emergency rooms, upon police or sheriff request, upon arrival at a crisis house or other emergency services, and at a person's home or other community site.

Inpatient Services:
Kalispell also has available Pathways, a 37-bed inpatient, secure treatment facility.

Outpatient Services: Kalispell is home to a WMMHC outpatient mental health center which provides a full range of case management, day treatment, psychiatric services and individual treatment through its Lamplighter facility.

Children's Services: in Flathead/Kalispell, AWARE has 2 therapeutic group homes (8 beds) for boys. Youth Homes, Inc. operates the juvenile shelter care program and numerous therapeutic foster care homes. WMMHC operates a therapeutic group home for 8 adolescent girls and a full range of outpatient services including individual treatment case management, psychiatric services, intensive in-home services and therapeutic foster care support. In FY 06, WMMHC child programs served 330 unduplicated individuals.

Chemical Dependency Treatment: the Flathead Valley Chemical Dependency Center is also located in Kalispell, and it provides outpatient and preventive services. Also, some of Pathways' adult psychiatric beds are made available for inpatient chemical dependency services.

Vocational Services: WMMHC in Kalispell has had a designated staff person providing employment related services in Flathead County but that position is currently vacant. The PACT reportedly has a person designated to provide employment services.

- **Libby/Lincoln County**

Crisis Response: Lincoln County utilizes an on-call system which requires licensed clinicians from WMMHC to rotate after hours call responsibilities among the available

pool of staff, in addition to their other full time assignments. The ability to retain clinicians under this arrangement has been a historical problem and remains a problem.

Outpatient Services: Libby is home to a WMMHC outpatient mental health center, which provides a full range of case management, limited psychiatric services, adult day treatment and individual treatment through a staffed facility. The clinic site serves both adults with serious mental illness and youth who are emotionally disturbed. Isolation and distance (100 miles from Kalispell) from other supportive services makes this service center especially challenging. In FY 06, Lincoln County WMMHC programs served 293 unduplicated individuals. This community has been affected in a major way by the loss of timber industry jobs over the past decade, compounded by health concerns associated with asbestosis.

Vocational Services: WMMHC in Libby has expressed interest in providing employment services and has visited with Vocational Rehabilitation staff.

- **Ronan/Lake County**

Tribal Services: this county is unique in the Western region in that it is home to the Confederated Tribes of the Salish and Kootenai. Tribal government oversees a well qualified and full-time staffed mental health program for enrolled tribal members.

Crisis Response: Lake County provides after-hours crisis telephone support and limited face to face interventions, but does not have a mobile team. Lake County utilizes an on call system which requires licensed clinicians from WMMHC to rotate after hours call responsibilities among the available pool of staff, in addition to their other full time assignments..

Outpatient Services: Ronan is home to a WMMHC outpatient mental health center, which provides a full range of case management, limited psychiatric services, CSCT programs in the schools, and individual treatment through a staffed facility. The WMMHC recently opened a clinic site in Polson to better serve residents in the northern section of Lake County. In FY 06, Lake County WMMHC programs served 475 unduplicated individuals. The county is also served by a number of other private providers.

Chemical Dependency: chemical dependency services are provided by Lake County Chemical Dependence, which is overseen by the County.

Vocational Services: WMMHC in Polson has expressed interest in providing employment related services and has attended at least one meeting with Vocational Rehabilitation.

- **Hamilton/Ravalli County**

Crisis Response: Crisis Response: Hamilton/Ravalli County does not have an official crisis response team, but it does have staff available through a special contract between WMMHC and Ravalli County who can be called to assist a person in a crisis. The contract also has provision for assessment and treatment of jail inmates and training and weekly consultation with detention staff.

Crisis Residence: FY 2006, WMMHC has received funding from DPHHS to begin the process to create a crisis house in Hamilton. The facility is expected to open by early summer 2007.

Outpatient Services: WMMHC offers individual and group therapy, adult and youth case management, adult day treatment, psychiatric services, intensive in-home supports and CBR support in Ravalli County. In FY 06, Ravalli County WMMHC MH programs served 624 unduplicated individuals.

Inpatient Services: Marcus Daly Hospital currently makes available one locked room for an in patient secure bed for a person in a psychiatric emergency.

Chemical Dependency Treatment: there is a branch of Western Montana Addiction Services (WMAS) in Ravalli County. The facility offers treatment for co-occurring disorders (i.e., mental health and chemical dependency issues). Services available include: one-on-one counseling, assessments and evaluations, group counseling (including intensive outpatient, outpatient, and Dialectical Behavior Therapy), state-certified adult and 18-21 ACT programs, school-based adolescent prevention, education, intervention, and treatment services, and community-based education and coalition-building services.

Vocational Services: WMMHC has recently designated a part time person to provide employment related services in Ravalli County. She will develop a program which will set up work assessment sites in the community, provide job search assistance or job coaching, or coordinate supported employment services (extended follow along support). She will serve as a liaison between WMMHC – Ravalli and Vocational Rehabilitation.

- **Butte/Silver Bow County**

Crisis Response: A consortium of Butte/Silver Bow, Powell, Deer Lodge, Beaverhead, and Granite Counties plus the several community hospitals in those counties fund a mobile crisis response team (CRT) which primarily serves the Butte, Anaconda and Dillon areas.

Crisis Residence: Butte also supports a residential crisis stabilization facility, Gilder House, which currently is licensed for 8 beds. Gilder House is generally full and currently has no capacity to provide secure detention beds. Consequently, many individuals in emergency situations are sent to MSH from Butte/ Silver Bow County. WMMHC is planning to replace the existing Gilder House and to increase its capacity to 12 beds, including 4 secure beds, (including the ability to provide medically cleared

detoxification). The additional crisis response beds will be made possible through a combination of the award of specially-targeted AMDD crisis response monies and alternative financing. However, this expansion is not expected to be completed until the summer of FY 2007.

Outpatient Services: WMMHC provides a range of services in Butte, Anaconda and Deer Lodge including case management, psychiatric services, medication management, and day treatment. In FY 06, Butte/Silver Bow County /WMMHC adult MH programs served 1,413 unduplicated individuals. AWARE also provides adult case management services and has a group home in Butte.

Children's Services: AWARE has 3 therapeutic group homes for children in Butte. AWARE also offers youth case management in Butte. WMMHC offers individual and group therapies, as well as psychiatric management, comprehensive school and community treatment (CSCT) programs, youth case management, and in-home intensive family based services. In FY 06, Butte/Silver Bow County /WMMHC child MH programs served 229 unduplicated individuals. Kids Behavioral Health (KBH) in Butte is the only children's residential treatment program in the Western service area. KBH has struggled for many years under various corporate entities to provide minimally adequate care for children with SED. For part of 2005, the Montana State Licensing Division curtailed KBH's ability to accept new residents due to inadequate staffing, excessive use of seclusion and restraint, inability of staff to protect the children from each other and other problems. Consequently, relatively large numbers of high needs children are only able to obtain appropriate services out-of-state.

Vocational Services: WMMHC in Butte has a designated staff person providing employment related services which include setting up work assessments in the community, providing job search assistance and job coaching, and possibly providing some supported employment. This person also travels to Dillon, Deer Lodge, and Powell county when Vocational Rehabilitation has consumers in those areas.

- **Anaconda/Deer Lodge County**

Outpatient Services: AWARE has 2 group homes for adults with mental illness in Anaconda. AWARE also provides case management and supported-living services for people with mental illness in Anaconda. WMMHC programs in Deer Lodge/ Anaconda include youth and adult case management, outpatient individual and group therapies and psychiatric medical management. In FY 06, in Deer Lodge County, WMMHC mental health programs served 291 unduplicated individuals.

Children's Services: AWARE offers youth case management services in Deer Lodge and Anaconda.

Chemical Dependency Treatment: Western Montana Addiction Services has a satellite office in Deer Lodge.

Vocational Services: See Silver Bow County.

- **Philipsburg/Granite County**
  No adult mental health services known.

  Chemical Dependency Treatment: Western Montana Addiction Services has a satellite office in Granite County.

- **Virginia City/Madison County**
  No adult mental health services known.

- **Dillon/Beaverhead County**
  No adult mental health services known.

- **Deer Lodge/Powell County**

  Children's Services: AWARE runs the Galen Campus in Powell County at Deer Lodge which has 6-7 houses for very high needs children: Gold Creek (4 boys), Lost Creek (4 boys), Pintler (4 girls), Mt. Powell (4 girls), Washoe (4 boys), and Clark Fork (2-4 boys). These children require some of the most intensive services in MT outside of Residential Treatment Facilities. The services are created and tailored to each child so they may include a wide range of wrap-around services. Each house has 4 beds. One has closed but is expected to reopen with only two beds and very intensive staffing. The Great Divide School District provides day treatment and education for the kids at Galen.

  Chemical Dependency Treatment: Western Montana Addiction Services has a satellite office in Powell County.

  Vocational Services: See Silver Bow County.

4.2 Critical Service Needs

At the January 2006 WSAA Board of Directors' meeting, the following critical service needs for the region were identified and organized, by priority, in the following order:

(a) **Presumptive eligibility:** for 72 hours at local hospitals, crisis services, and Mental Health Centers;

(b) **Emergency assistance:** statewide 24/7 emergency assistance to local hospitals, including psychiatric consultations by Montana State Hospital (MSH) staff (or mental health centers/private providers) and video conferencing for consultations;

(c) **Emergency room professional assistance and training program**;

(d) **Automatic enrollment in mental health system:** for individuals at imminent risk;

(e) **Discharge medications:** for patients leaving MSH (i.e., consumers leave the hospital with sufficient medication to last until consultation with a local psychiatrist);

(f) **Increase in the MHSP poverty level:** from 150% to 200% of poverty level, to match the poverty level for co-occurring disorders coverage;

(g) **Training for law enforcement personnel:** to work humanely with individuals in a mental health crisis;

(h) **Peer support services:** such as drop-in centers (e.g., "The Hub" in Billings), NAMI's Peer-to-Peer program, and Montana Mental Health Association's WRAP training;

(i) **Enhanced services for 90 days:** for all MSH (and community hospital) discharges;

(j) **Higher reimbursement rates:** to assist in the recruitment and retention of professional mental health staff;

(k) **Humane transportation:** of consumers with mental illnesses to involuntary services (e.g., MSH, ER's, and MHC crisis services) and to court hearings in a manner that respects dignity;

(l) **Upgraded crisis bed availability:** including secure beds where needed and architecturally reasonable;

(m) **Enhanced PACT services:** such as increased flexibility on eligibility, including when youths with mental illnesses transition to the adult mental health system);

(n) **Special needs wrap-around funding for MSH discharge patients:** e.g., paying rent for a period of time until they can get setup locally;

(o) **Patient assistance in community settings**;

(p) **Crisis Help Line:** to provide statewide, centralized, 24/7 assistance and referral;

(q) **Better access to pre-adjudication evaluations:** in community jails and detention centers, both for forensic purposes (i.e., diversion) and for competency evaluations;

(r) **Hospital crisis aide reimbursement**;

(s) **Higher daily reimbursement to community hospitals**;

(t) **Regional assessment and (inpatient) evaluation centers**; and

(u) **Transitional services and supports for individuals with mental illness who are released from prison or jail:** in order to access community mental health services.

4.3 Potential Obstacles

The WSAA has identified the following as potential obstacles which may interfere with our effectiveness in helping the public mental health system address these critical service needs:

(a) **Lack of political focus and will to improve the mental health system:** It is an unfortunate reality that legislators cut programs for people with little political clout. Few people have less power in our society than mental health consumers, and the stigma surrounding mental illness makes it even less likely that their needs will be discussed and attended to. (This stigma remains strong, despite significant efforts made by NAMI and the Montana Mental Health Association to educate the public.)

(b) **Lack of organization among people working in and using the public mental health system:** The system of care is fragmented, leaving many gaps in the "safety net". There are multiple providers located primarily in urban communities, with the rural parts of the state primarily underserved. Because there are no clear lines of who is responsible for what, many providers "cherry pick" those services that are financially advantageous to their organization. Medicaid eligibility for adults can take up to two years and multiple appeals to achieve, and because Medicaid is the ticket to most services, the individual and his/her family endure countless hardships with multiple hospitalizations and crises before they are recognized as "eligible and in need of services". Although it is widely recognized that early intervention and treatment is the best predictor of treatment success, treatment is often delayed until a major disability has taken hold. By default, the state hospital system has become the front door for treatment access for many people. Most people working in the system are overwhelmed by the sheer inertia of the system, and most people using the system are focused on survival, both physical and financial. It is difficult for these stakeholders to invest the time and energy needed to force system change.

(c) **Compassion fatigue and burnout:** many professionals, consumers, and other stakeholders in the public mental health system have witnessed multiple "reform" efforts and participated on multiple committees, task forces, and advisory boards that have (unfortunately) done little to change the system or address its problems. Understandably, consumers and other stakeholders are increasingly reluctant to get (and stay) involved unless they see results.

(d) **Difficulty hiring and retaining competent professional staff:** even if the public mental health system develops/implements some of the services needed, high turnover in competent professional staff and difficulty in recruiting and retaining such professionals at Medicaid reimbursement rates will likely remain barriers to care. The State of Montana has largely ignored these workforce retention issues by systematically not funding cost-of-living adjustments in an industry that it is responsible for "privatizing". The salary disparity issues are compounded by State hiring practices: state positions similar to those in the provider agencies are hired at a rate 20-30% higher than that which not-for-profits can offer/sustain. With the exception of the operation of the Montana State Hospital, the public mental health system is a privatized, not-for-profit industry. In

addition to base salary concerns, other financial benefit/compensation issues facing the state and not-for-profits are: affordable health insurance, rising worker's compensation rates, high travel expenses for a mobile work force, and lack of retirement programs. The State is sometimes accused of tunnel vision (or no vision) when it comes to ensuring that a viable system is in place when it makes a decision to privatize an industry.

(e) **Difficulty obtaining local, intensive mental health supports and resources:** due to low reimbursement rates and lack of training/interest, most intensive services in Montana are provided at a centralized, remote location rather than through local emergency rooms and community hospitals. This arrangement forces more and more people into MSH, further isolating them from their community supports and families and reducing their chances for recovery.

(f) **Criminalization of the mentally ill:** this phenomenon has been well documented both nationally and in Montana. Advocates and families become almost powerless when a person with mental illness is incarcerated for even low-level crimes. The public defender system is overwhelmed with criminal matters and rarely has the resources or training to work effectively with people with mental illness. Although many law enforcement personnel do not want people with mental illness in their jails, they sometimes find incarceration to be a preferable alternative to making multiple trips to the ER or having officers wait hours for an exam, only to watch helplessly as the individual is released back to the community to foster new complaints to which they must respond. As it becomes more difficult to obtain community services in a timely fashion, jails and prisons are becoming the default system of last resort because they cannot refuse to accept someone. Because of the unavailability of non-Medicaid funding, many criminal justice referrals (who also often do not meet the rigid diagnostic criteria for SDMI adult eligibility) languish in local jails and regional prisons. Even when they have major psychiatric problems, individuals being released from prison have no assurance of any follow-up mental health care upon release. The cycle of recidivist violations with the former inmate returning to prison/jail is the most likely outcome.

(g) **Lack of consumer involvement in quality control of community services:** community providers are not directly accountable to consumers, but rather to funders and licensing/credentialing bodies. If consumers were in charge of doing regular quality-control interviews and follow-up, providers would probably be more responsive. (NAMI is supporting such a policy.)

(h) **Lack of realistic financing for public mental health services in the community:** a disproportionate and politically-protected amount of funding goes into institutional care, starving community services. Consequently, too many dollars are spent on crisis response, rather than on prevention, skills-building, or recovery.

(i) **Over-reliance on Medicaid Funding:** the public mental health system in Montana (and in most other states) is largely reliant on Medicaid funding for persons living in their home communities with mental illness. In Montana, the ratio of Medicaid funding to non-Medicaid funding is extremely weighted toward Medicaid, especially in the

community service sector (~ $34M in FY 2006). The other significant financing comes from state general funds which fund care at Montana State Hospital (~ $20M in FY 2006) and a very small state general fund allocation for the MHSP program (~ $2.3M in FY 2006). In practice, this over-reliance on Medicaid funding means that persons living with mental illness who do not qualify for Medicaid or other health insurance have very limited (if any) treatment options. In addition, their access to care will continue to shrink as providers are forced to implement cost controls to cover their mounting losses resulting from cuts to the Medicaid and MHSP budgets.

(j) **Shrinking Federal Medicaid budget:** "reform" under the current Administration has resulted in cuts to the Medicaid budget. Consequently, even those consumers with Medicaid are eligible to receive fewer mental health services than in the past.

(k) **Competing priorities:** at a time when the nation's economy is in decline, when the budget deficit is growing at a rapid pace, and when other high-visibility priorities (e.g., the war in Iraq, hurricane relief) compete for attention and dollars, it is challenging to keep chronic issues/needs such as mental illness on the radar screen.

(l) **Stigma and lack of education regarding mental illness:** it is difficult to advocate on behalf of individuals with mental illness because there continues to be so much stigma, misinformation, and fear associated with their needs.

(m) **Potential threats to the survival of the SAAs:** in October 2005, the SAAs appeared jointly in front of the legislature to advocate for continued support for SB 499, the Senate bill that established the SAAs. Should the legislature choose to stop supporting this bill, the SAAs would likely lose both their authority and their funding.

(n) **Strength/influence of AMDD:** the WSAA (and other SAAs) were developed specifically to collaborate with AMDD. Therefore, it makes sense to assume that the WSAA's ability to influence the public mental health system will depend, at least in part, on AMDD's ability and willingness to collaborate effectively and to pursue actual system changes, given the current political/financial climate.

Thus far, the SAAs and AMDD have collaborated effectively in a number of ways, including:

(1) Forming and funding of the SAAs, and funneling funding to the LACs. AMDD was very supportive of the SAAs' desire to fund LACs out of SAA grants, and it made the process simple by requiring no AMDD approval and little paperwork.

(2) Getting AMDD to LACs for Listening tour and prioritizing crisis management suggestions created from listening tour 3.

(3) Collaborating on the Executive Planning Process (EPP), including getting 3 out of 4 of the SAAs' top priorities into the EPP and getting 72-hour presumptive eligibility for crisis services expanded to cover Mental Health Centers (MHCs)

and other community providers instead of limiting such eligibility to hospitals only.

(4) Collaborating on the RFP process to increase community capacity by including SAA representatives on the team that awarded monies, and by following their recommendations to fund emergency care capacity building as a priority.

(5) Collaborating on data collection for this strategic plan. AMDD was very helpful in providing data, but further collaboration will be needed to encourage AMDD to begin to keep data by SAA region (as opposed to state-wide numbers only).

(6) Having AMDD representatives participate in the SAA process at Board and Summit levels, i.e., attending Board meetings of Dan Ladd and Mary Jane Fox among others, hosting the SAA Summit, and using the Summit meetings to share information with and get feedback from the SAAs.

(7) Having AMDD support increased line-item funding for the SAAs.

There have also been several areas in which the new working relationship between AMDD and the WSAA has not yet produced outcomes that the WSAA has recommended or desired, suggesting the need to improve communication and collaboration. WSAA recognizes that the relationship will continue to develop as the parties continue to work toward common goals. Ongoing areas in which the WSAA would like to improve collaboration include:

(1) Although it is still one of the WSAA's top priorities to increase financial eligibility for MHSP to 200% of poverty level, AMDD was unable to recommend this priority after the executive planning process or through the SJ 41 Subcommittee testimony.

(2) The WSAA would like AMDD to consult with the WSAAs regarding decisions to apply/not apply for significant sources of funding (e.g., the Money Follows the Person federal initiative, SAMHSA funding, other substantial grants) that would help to defray the costs of Olmstead-mandated transitions from mental health institutions to community supports and services.

(3) The WSAA would like AMDD to collaborate intensively with the SAAs re: the AMDD legislative agenda, including additional funding for MSH and the Mental Health Services Plan.

(4) Due to timing issues (i.e., the SAAs weren't formed before decisions had to be made), AMDD and the SAAs were not able to consult effectively on a Medicaid waiver proposal that essentially leveraged all MHSP general funds to fund non-mental health expansion of Medicaid coverage, with only a minimal increase in services for people with mental illness. The WSAA would like the opportunity to

be more involved in the development of waivers that affect the use of substantial amounts of dollars used for mental health services.

(5) Finally, the WSAA would still like to see improved access to community mental health services (as contrasted to crisis beds or institutional placements). Currently, consumers without Medicaid have extremely limited treatment options in the community, and even those consumers with Medicaid coverage have very little control over their own treatment.

5.0 STRATEGY AND IMPLEMENTATION SUMMARY

The WSAA proposes to adopt the following strategies in order to maximize its effectiveness:

(1) **Conduct a Market Analysis:** survey and develop a clearer picture of the current status of mental health services in Western Montana, including the location and type of services available, and the number and type of consumers in need of those services.

a. The WSAA is currently collecting data regarding the incidence of individuals with mental illness incarcerated in Western Montana, including those housed at Montana State Prison at Deer Lodge.

b. In addition, it would be helpful to understand approximately how many individuals receive mental health treatment services through private payment or insurance, how many individuals receive "mental health" treatment through their primary care providers, and how many individuals are cared for in/by their families without treatment.

c. The WSAA should contact Vocational Rehabilitation services regarding supported employment services offered for people with SDMI. Because employment is such a critical component to individuals in their recovery, all parties need to prioritize this service domain so that individuals can receive necessary supports and treatment while at the same time building their job skills and employment histories.

d. Lastly, WSAA will develop a clearer picture of the number and type of treatment slots (e.g., inpatient beds, crisis treatment slots) available in the Western region.

(2) **Conduct a Needs Assessment:** identify deficiencies, community needs, and service priorities through input from the LACs, WSAA Congress and Board, community providers, and other stakeholders.

a. In December 2005, the WSAA identified four top priorities: (1) improve crisis stabilization in the region, (2) develop peer-to-peer initiatives (e.g., peer-run drop-in centers or supports, training), with Medicaid reimbursement for peer services, (3) develop, promote, and adequately fund a state policy for the humane transportation of consumers to/from mental health services (including MSH) that respects dignity and

does not use law enforcement vehicles, and (4) provide funded access to community-based mental health services regardless of income.

b. In January 2006, the WSAA prioritized the "Crisis Management Initiatives" as proposed by AMDD from its listening tour. These crisis management initiatives are designed to expand on the more general priorities identified above to improve crisis stabilization in the region and to provide funded access to community-based crisis services, regardless of income. Both the CSAA and ESAA adopted the same priorities, and AMDD used the priorities to help establish its budget requests.

c. Throughout the legislative interim, WSAA has provided testimony and priorities to the SJ 41 Legislative Interim Committee on Children, Families and Health and Human Services. The four top issues identified to the SJ 41 committee expand upon the December 2005 priorities. WSAA asked the SJ 41 Committee to consider the following: (a) expand 72-hour presumptive eligibility to anyone who is seeking crisis mental health services through any public avenue, (b) increase financial eligibility for the MHSP to 200% of the federal poverty level to close the gap between eligibility for chemical dependency and co-occurring services and mental health services, (c) provide community-based crisis response for people who are not Medicaid- or MHSP-eligible at the time of crisis without regard to ability to pay, and (d) provide adequate reimbursement to local hospitals for mental health crisis beds for up to 3-4 days to encourage development and maintenance of crisis beds in the community.

d. The WSAA will re-visit priorities regularly, as situations change and develop. At the same time, the WSAA hopes to provide an over-arching vision that is not subject to the vagaries of budgetary and political processes.

e. The WSAA sent out a needs assessment form to the LACs and now needs to collect them. Depending on the response rate, we will analyze the data received or develop a shorter, more user-friendly version to increase participation in the assessment process.

f. The WSAA Board Chairman has been asked to include an update from the LACs in the board meeting agenda.

g. The WSAA will follow up on the Butte Crisis Survey (contact: Michelle Lewis) and on the statewide survey (contact: Dan Ladd) to obtain results.

h. The WSAA Board will develop a needs assessment with the WSAA Congress.

(3) **Present a Unified Voice:** collaborate, coordinate efforts, and combine resources with the Central and Eastern SAAs and other community mental health groups (e.g., NAMI and the MT Mental Health Association), when appropriate.

a. The WSAA website facilitates collaboration with representatives from the Eastern and Central service area regions. Currently, the CSAA has joined the WSAA on the combined website to aggregate information and resources. Both SAAs fund a

webmaster to post and update information in a timely manner and to find useful information for visitors to the website.

b. The three SAAs coordinate their efforts through Summit Meetings at which they collaborate with AMDD, identify issues of common interest, select action steps, identify who will perform the action steps, and set timetables for completion.

c. The three SAAs have jointly adopted priorities for crisis response to assist AMDD to develop its budget requests.

d. The three SAAs will collaborate to present testimony to various legislative committees, jointly write letters to legislators, AMDD, DPHHS, and other policy makers, and provide joint position papers on proposed legislation, when time allows.

e. On an ad hoc basis, the three SAAs will develop position statements (e.g., the CSAA letter from Tom Peluso to AMDD).

f. The three SAAs may develop a Legislative Committee to work together, and the Summit has created a Long-Range Planning Committee.

g. The three SAAs will develop a process through which they can communicate in a more timely manner.

(4) **Collaborate with AMDD/DPHHS:** to develop the Governor's budget priorities, to identify service priorities and develop methods to meet those needs, and to encourage the development of a consumer-run quality control system for mental health services in Western MT.

a. Representatives of AMDD/DPHHS already attend most of the WSAA Board meetings, Summit meetings, and Congress meetings.

b. AMDD/DPHHS has been helpful in sharing data with the WSAA.

c. The WSAA responds to requests for information, prioritization of needs, and consumer perspectives on a variety of issues for AMDD.

d. The WSAA provides input and priorities for the AMDD portion of the Executive Planning Process.

e. The WSAA, in conjunction with the other SAAs, provide guidance and direction to AMDD regarding time-sensitive issues.

f. The WSAA helps AMDD identify and meet with local LACs for its listening tour.

g. MHOAC representation will continue to include three SAAs. The SAA will use representatives to reflect and promote the SAA priorities. SAA will promote direct SAA appointment to MHOAC.

(5) **Participate in the Legislative Process:** educate legislators regarding needs and priorities of consumers in the mental health system, work with appropriate legislative interim and standing committees to educate and inform regarding consumer needs and priorities, draft (where appropriate) mental health-related policies.

a. At its June 2006 Board meeting, the WSAA nominated members for a "Legislative Sub-Committee," the charge of which is to review proposed bills, draft position statements for Board approval, create teams to provide education or comments to legislative committees (so as to include all), and work with consumers to convey effectively their "stories" to illustrate the need for easier access to/more community-based services, among other needs.

b. The WSAA will complete, with extensive input from the LACs, the statutorily required biennial regional report by mid-Fall, to give legislators the "state-of-the-state" update re: what is/isn't working in the public mental health system. These community-level reports will be compelling to legislators who are principally concerned about their constituencies.

c. The WSAA anticipates developing a legislative "action plan" of goals, and then an implementation plan that includes:

(1) Training the LACs and SAAs on how to communicate with legislators in a timely and effective way;

(2) Setting up phone and e-mail trees for quick response to legislative requests for information and testimony; and

(3) Developing packets for LAC and SAA members to use to organize community meetings with their legislators.

d. Once the SAAs have seen what the governor's budget proposal does and doesn't include, and what legislation is being written, they can begin to have discussions at the local and regional levels, and then coordinate the overall SAA response at the Summit level. These discussions will inform the content of the position papers developed by the Legislative Sub-Committee.

e. The WSAA will develop policies and practices to address member presentations in response to public or legislative requests for WSAA positions on various issues. Dan Ladd, Regional Planner for the Mental Health Bureau of AMDD, will present an outline of a system to address public presentation of SAA policies.

(6) **Engage in Grant-Writing and Other Fund-Raising:**

a. The WSAA recently established a "Grants and Fund-Raising" Sub-Committee.

b. The WSAA plans to employ a grant-writer (with or without the other SAAs) to obtain funding for unfunded priorities;

c. The WSAA will coordinate with providers and other stakeholders to develop/identify additional funding sources for needed mental health services.

d. The WSAA will urge AMDD and DPHHS to apply for new federal Medicaid ($1.5 billion in "Money Follows the Person") funding. These monies are being made available over 5 years to states through the Center for Medicare and Medicaid Services (CMS) under the President's New Freedom Initiative and the Deficit Reduction Act of 2005. "Money Follows the Person" funding is targeted to assist states make the transition from institutional care to community-based supports and services and offers incentives of up to 90% federal matching for states to develop services to transition people out of institutions.

e. The Montana Mental Health Association (MMHA) will apply for a grant to provide training for WSAA members in systems change.

(7) **Promote "Best Practices":**

a. The WSAA hopes to encourage and support the use of evidence-based practices (EBPs) (i.e., practices that have been demonstrated to be effective by empirical research) by bringing speakers and experts to Montana (or utilizing "local" experts, such as NAMI representatives) to train providers and other community stakeholders about the practices and their (cost-)effectiveness.

b. The WSAA hopes to educate system stakeholders and legislators about EBPs and emerging best practices which have been demonstrated to be effective (or shown to be promising) in the treatment of adult mental illness, including: assertive community treatment, consumer-run/peer services, crisis services, illness management, integrated treatment for individuals with co-occurring mental illness and substance abuse, newer medications and medication management, psychiatric rehabilitation, psychodeducation for families, psychotherapy, supported employment, and supported housing. (For more information on these practices, see The Campaign for Mental Health Reform website (http://www.mhreform.org/policy/ebs.htm.)

c. The WSAA also hopes to educate system stakeholders and legislators about barriers to the effective implementation of EBPs. A 2004 survey by the National Research Institute of the National Association of State Mental Health Program Directors (NASMHPD) identified the following obstacles in Montana: shortage of an appropriately trained workforce, financing issues, modification of the EBP model to meet local needs, attaining or maintaining fidelity to EBP model standards, and resistance to implementing EBPs from providers. (See their website for more information: http://www.nri-inc.org.) For example, although the Substance Abuse

and Mental Health Services Administration (SAMHSA) recommends that EBPs be followed, the the Centers for Medicaid and Medicare Services (CMS) does not provide adequate reimbursement to support such practices. Thus, additional sources of funding will need to be identified in order to implement EBPs in Montana.

d. The WSAA hopes to educate system stakeholders and legislators about efforts currently being made in Montana to implement EBPs. For example, in May 2004, DPHHS posted a Strategic Plan for Adult Mental Health Services which calls for the state to bring all stakeholders together to develop a comprehensive mental health plan, to include evidence-based practices. The University of Montana has established a Rural Institute to assist rural consumers throughout the country with anything from integrated childcare to supported employment. The Institute has formed the American Indian Disability Technical Assistance Center, which offers culturally competent technical and vocational assistance to Native Americans with and without disabilities. The state has also published its 2006 Block Grant Application, which outlines the goals and strategies of the state with regards to EBPs, among other mental health initiatives. (See http://www.nri-inc.org for more information.

e. The WSAA will continue to receive input from the Montana Mental Health Association (MMHA) regarding its science-to-service message. MMHA was recently awarded an NIMH Outreach Partnership contract to ensure that information on the latest research findings is disseminated to stakeholders in Montana.

f. The WSAA plans to communicate with other rural states to promote practices (e.g., humane transportation of consumers) that have proven effective elsewhere.

g. The WSAA will work to insure cultural competency within its own operations and within the public mental health system (e.g., a subcommittee will be created to research possible cultural competency training options for the WSAA, AMDD, DPHHS, and/or providers within the system). Given that many EBPs have not been proven to be appropriate or effective in all settings and for all racial, ethnic and cultural populations, the WSAA will also work to promote research on the effectiveness of interventions for people of diverse cultural and ethnic backgrounds, with a particular emphasis on Native Americans. These efforts would help to ensure that culturally sensitive and appropriately trained mental health providers are employed to provide services to Native Americans and other cultural minority individuals living in Montana.

(8) **Promote More Consumer Involvement:** create more consumer-run support services and peer counseling services in Western Montana.

a. The WSAA will continue to solicit input from the LACs to identify local needs.

b. The WSAA provides funding to assist the LACs operate.

c. The WSAA board and Congress meetings provide a forum for LACs to share strategies to increase consumer involvement, participate in policy making, identify and share concerns, and share problem-solving strategies and resources.

d. The WSAA supports training in development and leadership as a priority for LACS.

e. The WSAA shares materials and resources with the LACs to further their mission.

f. The WSAA has made a commitment to pay for transportation, hotel, and other costs associated with consumer participation at Board and Summit meetings;

g. The WSAA, through its representatives in the AMDD RFP process, has supported the development of WRAP training, peer-to-peer support services, and peer-run drop-in centers. The WSAA continues to identify peer training and employment as priorities.

(9) **Promote Insurance Parity:** encourage and support efforts to promote insurance parity (i.e., to ensure that mental/behavioral health conditions are covered by health insurance to the same degree that health conditions are).

a. The WSAA will disseminate research findings in support of its position to legislators and other stakeholders. For example, a recent article in the *New England Journal of Medicine* (Goldman et al., "Behavioral Health Insurance Parity for Federal Employees," Vol. 354(13), pp. 1378-1386) concluded that, "When coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs."

b. The WSAA will research whether comparable studies have been done in the public health/mental health system.

c. The WSAA will educate the legislature about Medicaid limitations with regards to mental illness coverage (e.g., the fact that only certain mental health diagnoses are covered by Medicaid).

(10) **Participate in the AMDD RFP Process:** encourage and support providers or other stakeholders to develop responses to deficiencies in the public mental health system through the AMDD RFP process

a. WSAA Board Members were involved in the 2006 review, approval, and recommendation of projects from the WSAA Region to be considered by AMDD for funding through the RFP process.

b. WSAA representatives participated in identifying and selecting community projects to increase treatment capacity for people with mental illness and to extend the range of options available in crisis response throughout Montana. The crisis house in Butte was funded to expand capacity, and WMMHC was funded to start the development of a much-needed crisis house in Ravalli County.

c. The WSAA will continue to work with providers and community groups to prioritize needs and service areas for later development, should additional AMDD RFP's be issued in the future.

(11) **Rate the Mental Health System:** the WSAA will "grade" how the public mental health system has been doing, to keep stakeholders apprised of our progress.

a. The WSAA will issue its biennial review and evaluation of mental health service needs and services within the Western service area, as required by statute.

b. The WSAA will educate legislators and other system stakeholders about mental health "report cards" from the National Mental Health Association and NAMI, and AMDD's response. For example, the most recent report from NAMI rated Montana with an "F" overall for mental health services. AMDD responded by saying that the rating was inappropriate, as it was based on outdated services and did not include all the new work that has been done (e.g., adopting PACT teams).

c. The WSAA will also look at goals and deadlines that have been previously agreed upon with regards to the public mental health system, to help the state of Montana remain accountable.

6.0 MANAGEMENT SUMMARY

The WSAA management team consists of a Board of Directors with at least 51% consumer involvement and officers working closely with representatives of the other SAAs, the LACs, and AMDD. Ultimately, the work of the WSAA will be divided among sub-committees empowered to address particular issues and tasks.

WSAA Relationship with LACs

The WSAA is required by statute to collaborate with the Western region's LACs. The WSAA recognizes that effective interaction between the LACs and the WSAA will be necessary if the WSAA is to be truly responsive to both local and regional needs. The LACs were created by statute, predate the SAA system, and are reflective of early legislative intent to involve consumers in the design and operation of the public mental health system. The SAAs were subsequently created for similar reasons, but SAA collaboration is required (rather than advisory) for the DPHHS and AMDD. Therefore, the LACs and SAAs share common purposes and will benefit from pooling their information and resources. Essentially, the LACs operate as the local "building blocks" for an effective, regional SAA.

The LACs are required to work with the Mental Health Oversight and Advisory Council (MHOAC) through joint meetings, reports, and an interactive recommendation and proposal process (MCA §53-21-702(1)(b)). MHOAC has recommended that a primary focus of the LACs should be advising the SAAs regarding program issues affecting their communities. In addition, MHOAC has recommended that the LACs within an SAA region be represented on the Board of

the SAA and work together with the SAA. In response, the WSAA reserved for the LACs 10 of 19 seats on the Board of Directors, thereby ensuring (and institutionalizing) local, informed, and active consumer input into the development of the public mental health system.

WSAA Relationship with MHOAC

MHOAC is formed by the DPHHS to provide input to DPHHS/AMDD in the development and management of the public mental health system (MCA §53-21-702(4)). One half of MHOAC must be primary or secondary consumers of mental health services. All recommendations made by MHOAC must be transmitted by the department to the legislative finance committee, along with an explanation if the department fails to follow the MHOAC recommendations. As a condition for providing a block grant for state mental health services, the federal government requires a state planning council, and MHOAC fulfills this function in Montana. MHOAC is mandated to annually monitor, review, and evaluate the adequacy of both the adult mental health system and the children's mental health system and to report on its findings. Thus, MHOAC fulfills a state function similar to the combined three regional SAAs, and a federal function to ensure State compliance with federal funding requirements.

Like MHOAC, the WSAA is directed to collaborate with DPHHS/AMDD and the LACs to (1) plan, implement, and evaluate the public mental health system, (2) promote consumer and family leadership within the public mental health system, and (3) foster consumer-driven and family-driven systems of care that advance access to a continuum of mental health services and individual choice (MCA §53-21-1013). Until 2003, AMDD oversaw and influenced the structure of both the adult and children's public mental health systems. However, in 2003, the legislature separated the children's mental health system from the adult system and created a new Children's Mental Health Bureau with separate funding. Consequently, the two systems are now developing under separate direction. While the WSAA is directed to take into consideration the policies, plans, and budget developed by the children's mental health system, its primary focus is the functioning of the adult system. Transition planning for youth about to enter the adult mental health care system is essential to provide a seamless transfer and requires collaboration and understanding between the two systems. Nonetheless, MHOAC's mandate is more evenly divided between the two systems than is the WSAA's. Moreover, MHOAC is concerned with the requirements for federal funding, while the SAAs are more focused on collaborating with DPHHS to develop the executive budget for mental health services that will be presented to the legislature. In addition, the MHOAC takes a state-wide perspective, while the WSAA's primary mandate is to evaluate mental health services, identify deficiencies, and recommend improvements within its own (Western) region.

One of the tasks facing the WSAA will be to clarify its relationship with the other SAAs, MHOAC, and the LACs within its region, in order to address overlapping areas of influence and expertise, identify unique responsibilities, and coordinate their efforts.

6.1 Personnel Plan

At first, the work of the WSAA will all be done by the Board of Directors and the WSAA members. In the future, it is possible that the WSAA will elect to hire a part-time Executive Director to assist with administrative tasks. The WSAA may also decide to hire part-time

consultants with particular expertise (e.g., computer skills, grant-writing) deemed necessary to fulfill the organization's mission.

7.0 FINANCIAL PLAN

The WSAA receives $15,000 per fiscal year as a planning grant from AMDD. The WSAA may decide to leverage these funds by writing grants, requesting donations, etc. According to MCA §53-21-1006, the WSAA may:

(1) Enter into contracts with DPHHS for purposes of planning and oversight of the WSAA if the department certifies that the WSAA is capable of assuming the duty;

(2) Receive and shall administer funding available for the provision of mental health services, including grants from the United States government and other agencies, receipts for established fees rendered, taxes, gifts, donations, and other types of support or income. All funds received by the Board must be used to carry out the purposes of the part;

(3) Reimburse Board members for actual and necessary expenses incurred in attending meetings and in the discharge of Board duties as assigned by the Board.

To date, the bulk of the WSAA's funds have gone to pay the expenses of consumers who have traveled to attend Board, Congress, and Summit meetings. The WSAA Board has also authorized funds to pay a "webmaster" for the development and maintenance of the WSAA website. Lastly, the WSAA has adopted an interim policy to support financially the LACs within the Western region. There are now six (6) LACs within the WSAA region (Missoula, Kalispell, Libby, Hamilton, Lake, and Butte) that have formalized their structure sufficiently to receive financial support ($150 every 6 months, with occasional augmentations as necessary) from the WSAA. An additional two (2) LACs (Superior (Mineral County) and Dillon (Beaverhead County)) are in the process of formalizing their structure, which entails notifying local mental health consumers about the LAC, holding regular meetings, electing a treasurer, and obtaining an Employer Identification Number.

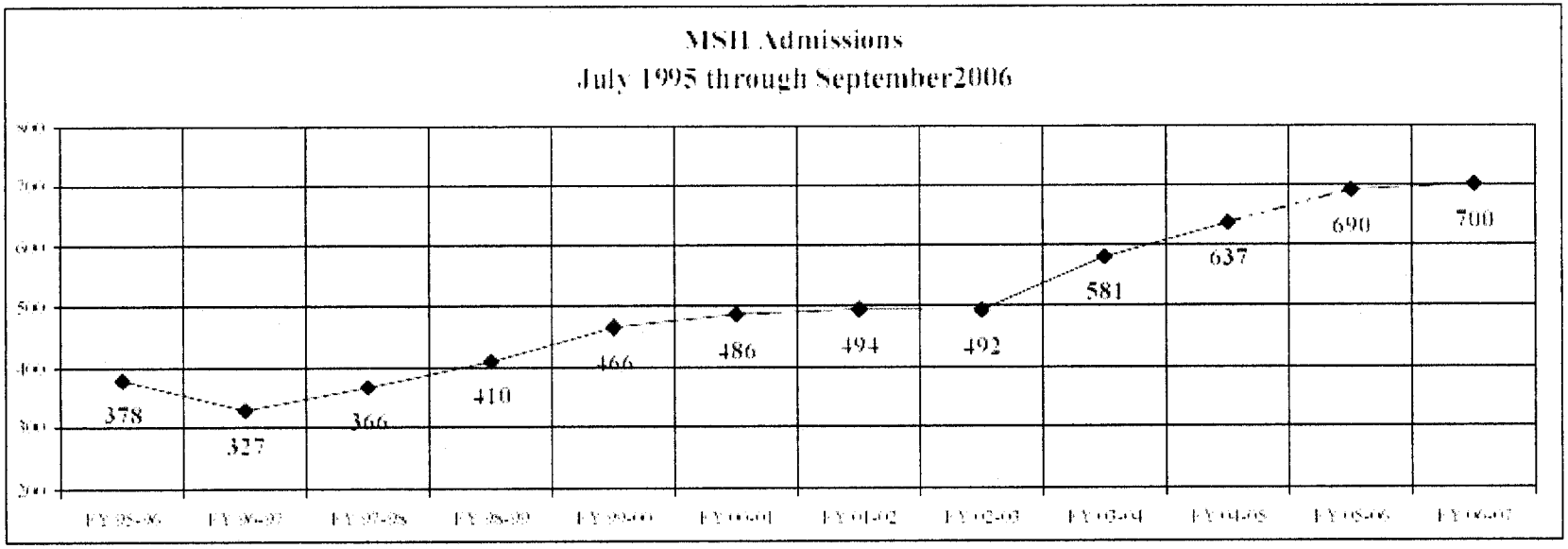
8.0 GLOSSARY/ACRONYMS

AMDD	- Addictive & Mental Disorders Division (of DPHHS)
Congress	- full WSAA membership
DPHHS	- Department of Public Health and Human Services
Executive Board	- President, Vice President, Secretary and Treasurer
LAC	- Local Advisory Council; a coalition of community members interested in assessing, planning, and strengthening public mental health services in their community
Primary consumer	- Individual with a mental disability
Secondary consumer	- Family member of a primary consumer

SAA	- Service Area Authority (e.g., Western, Eastern, and Central); an entity, as provided for in MCA §53-21-1006, that has incorporated to collaborate with DPHHS for the planning and oversight of mental health services within a service area
SB 499	- Senate Bill that established the SAAs' collaborative relationship with AMDD
Summit	- meetings of representatives of the 3 SAAs
WSAA	- Western Service Area Authority

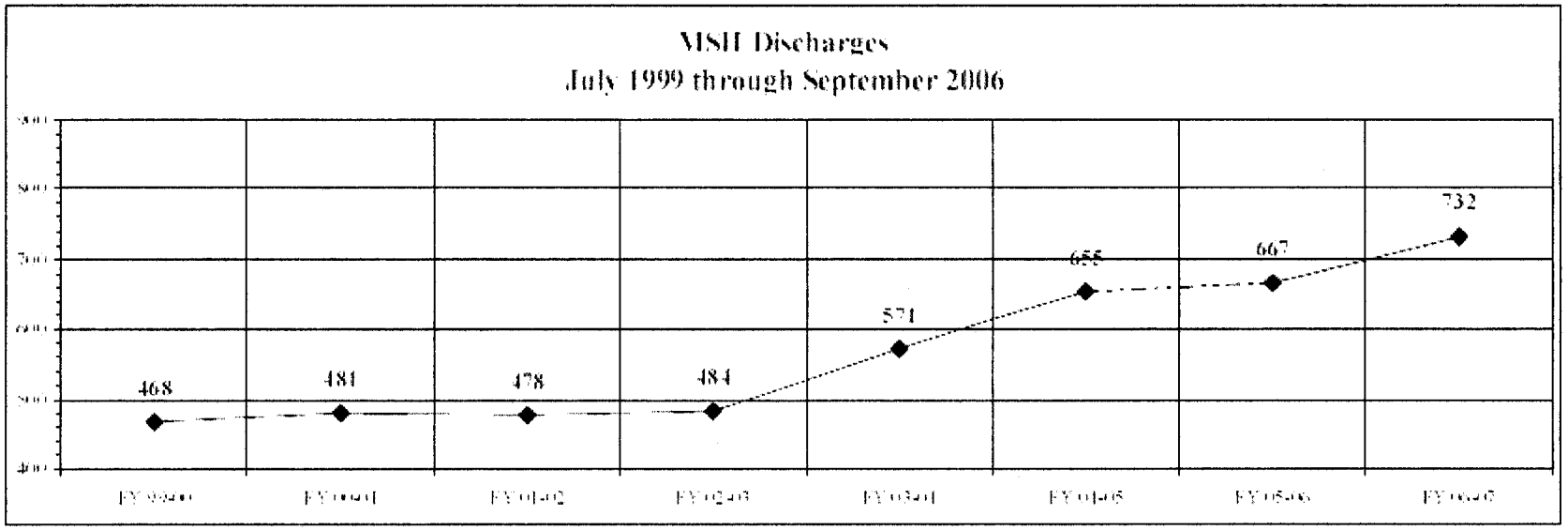
Admissions

	July	August	September	October	November	December	January	February	March	April	May	June	Total for Year
FY 05-06	50	39	43	32	28	33	32	30	32	23	32	30	378
FY 06-07	27	26	30	24	20	30	34	27	35	41	30	24	327
FY 07-08	25	29	32	33	20	25	32	29	30	39	34	30	366
FY 08-09	44	34	33	32	26	32	40	27	34	43	43	36	410
FY 09-10	27	40	34	38	35	23	42	35	56	44	44	49	466
FY 10-11	40	36	46	32	28	35	32	24	34	28	44	44	486
FY 11-12	43	42	35	36	34	40	39	36	46	54	42	44	494
FY 12-13	44	42	36	34	36	33	42	42	36	38	38	46	492
FY 13-14	47	56	57	58	52	38	50	43	44	43	47	57	581
FY 14-15	57	63	43	49	49	62	49	53	50	58	49	58	637
FY 15-16	60	57	52	75	42	65	42	54	62	53	62	62	690
FY 16-17	52	65	59										700
Projection for current year	612	696	700	729	682	698	669	666	673	682	686	690	



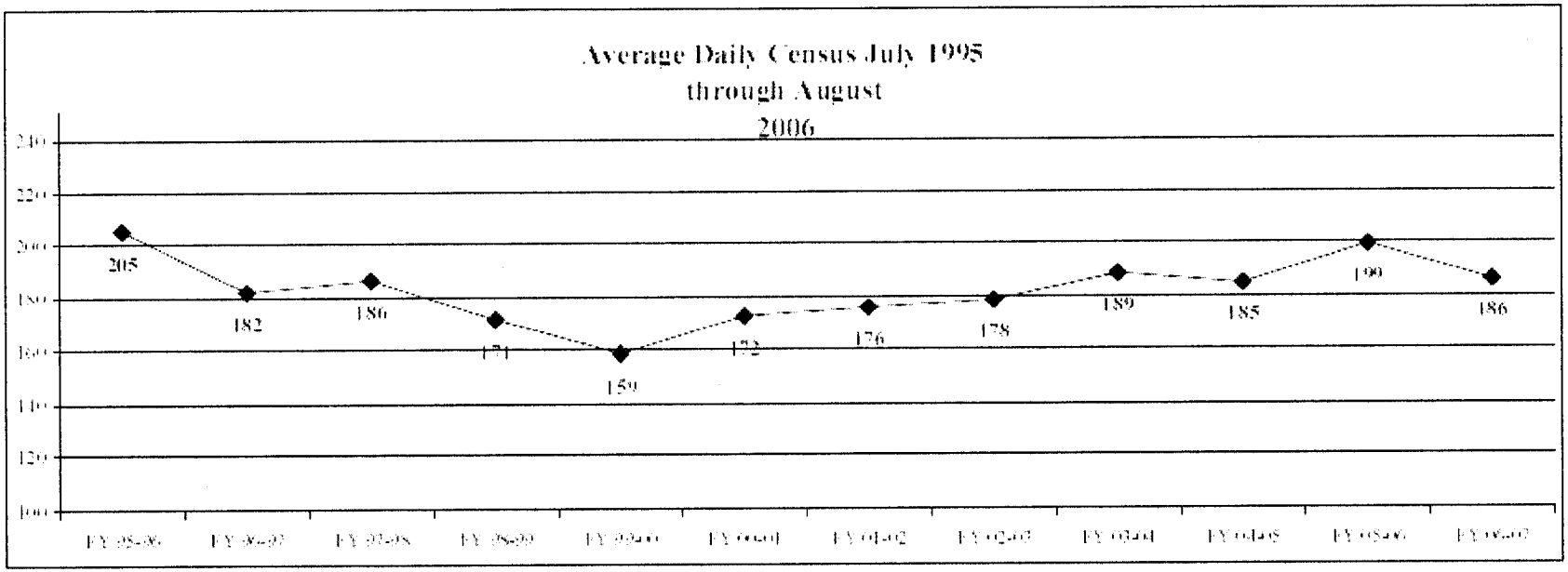
Discharges

	July	August	September	October	November	December	January	February	March	April	May	June	Total for Year
FY 00-01	29	40	38	23	28	60	36	34	46	55	44	37	468
FY 01-02	34	47	54	45	30	35	43	42	41	35	41	34	481
FY 02-03	38	37	46	36	33	34	46	32	44	48	47	37	478
FY 03-04	43	46	46	35	35	50	38	36	36	44	37	38	484
FY 04-05	51	47	58	46	49	52	38	50	49	45	40	46	571
FY 05-06	69	63	50	52	48	58	47	53	55	51	61	55	655
FY 06-07	48	58	53	68	46	51	55	57	47	56	63	70	667
FY 07-08	53	83	49										732
Projection for current year	636	804	732	675	650	650	651	647	637	641	651	667	



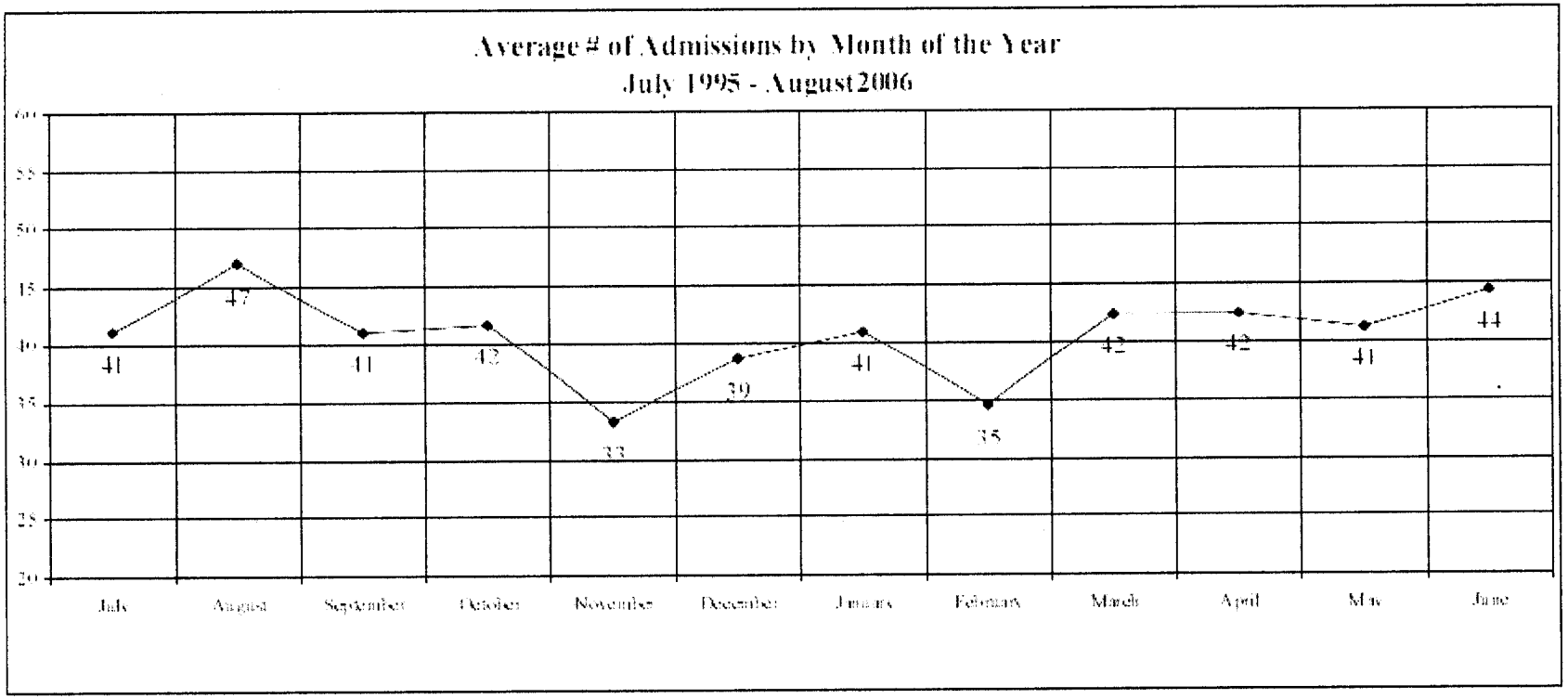
Average Daily Census

	July	August	September	October	November	December	January	February	March	April	May	June	Average for Year
FY 95-96	205	182	186	171	159	172	176	178	189	185	200	186	205
FY 96-97	190	184	182	175	172	169	176	173	172	198	198	196	182
FY 97-98	184	189	192	187	178	178	184	188	187	193	193	193	186
FY 98-99	189	184	178	174	171	163	170	166	158	168	168	173	171
FY 99-00	162	162	155	164	173	158	148	149	155	162	153	165	159
FY 00-01	164	185	180	172	183	177	182	177	168	159	159	166	172
FY 01-02	168	175	176	179	170	170	178	175	176	182	182	184	176
FY 02-03	177	181	178	170	177	167	181	187	185	183	180	178	178
FY 03-04	185	184	192	189	196	188	188	188	185	188	187	193	189
FY 04-05	190	193	186	185	182	182	182	182	191	191	178	177	185
FY 05-06	195	196	192	201	198	201	195	194	190	209	220	202	199
FY 06-07	191	182	186										186



Average # of Admissions by Month of the Year

July	August	September	October	November	December	January	February	March	April	May	June
41	47	41	42	33	39	41	35	42	42	41	44



Service Area Authorities 2007 Legislative Priorities

The Central, Eastern, and Western Service Area Authorities identify the following critical mental health funding needs and issues for the 2007 Legislative Session.

- Fully funding the Mental Health Services Plan (**MHSP**) equal to the number of services, types of services, and reimbursement rates offered by Medicaid. Persons with Severe Disabling Mental Illness (SDMI) living at 151-200 percent of federal poverty level should be allowed to access this service on a sliding fee basis.

- Funding for 72-hour presumptive eligibility (**72 PE**) for crisis services, statewide.

- Funding for community mental health crisis response services to include Mental Health Professional Crisis Response Teams; community inpatient resources such as Behavioral Health Inpatient Facilities; jail diversion programs for mentally ill offenders, and mental health advocates including Peer Specialists to support mentally ill persons during both civil and forensic commitments.

The Service Area Authorities believe that persons with severe mental illness are best served in the community so that mental illness/addiction is identified early and treated quickly. Community services are more cost-effective than higher levels of care outside of the community. People, who are in crisis because they are unable to get community services, often go to the Montana State Hospital (MSH) because it is the only place available for care. The Governor's budget funds growth at the MSH, but does not adequately fund community services to over 5,000 Montanans with severe and disabling mental illness (SDMI) living at less than 150 percent of the federal poverty level enrolled in the Mental Health Service Plan (MHSP).

These priorities fund community-based services that are unfunded or dangerously under-funded. In 2003, MHSP funding levels kept the Montana State Hospital (**MSH**) population at a reduced level. Now MHSP is funded at less than 50% of the 2003 level and the **MSH** operates above design and licensed capacity and, community crisis interventions are increasing. Because persons with severe mental illness remain untreated or underserved, funding for more expensive treatment continues to increase, and the Montana suicide rate is second in the nation.

Service Area Authorities gratefully acknowledge increased funding for community services in the Governor's budget; however, the funding does not well serve the very vulnerable MHSP population, nor does it provide for the services necessary to reduce the census at the Montana State Hospital.

The following organizations have written to DPHHS and/or the Governor's Office supporting the Service Area Authorities Critical Mental Health Funding Needs and Issues: • Sheriff's and Peace Officers' Association • Montana County Attorney's Association • Eighteenth Judicial District Court • Mental Health Oversight Advisory Council • Montana Association of Counties • Montana Mental Health Association • National Alliance On Mental Illness • Mental Health Local Advisory Councils

The Service Area Authorities urges the Montana Legislature to join them and these other organizations in support of improved community mental health services.